Exhibit A

AFFIDAVIT OF LEIGH-ANNE LEE

Comes now the affiant, Leigh-Anne Lee, who, having first been duly sworn, states that the following statements are true in regards to Plaintiff Ronda Burns:

1. All of the statements contained in this Affidavit are true and correct and made on the basis of my personal knowledge. I am an adult citizen of the State of Tennessee, over the age of 18 years, and am competent to make the statements contained in this Affidavit. I am a legal assistant with Galligan and Newman.

2. On July 8, 2013, I mailed by certified mail, return receipt requested a Notice letter and enclosures to Saint Thomas Outpatient Neurosurgical Center, LLC at both the addresses for the agent of service of process (Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste. 301, Nashville, TN 37203-2023) and the provider's current business address (Floor 9, 4230 Harding Pike, Nashville, TN 37205-2013 and I obtained certificates of mailing from the United States Postal Service stamped with the date of mailing as required by Tennessee Code Annotated § 29-26-121 (a).

3. I attach as Exhibit 1 a copy of the Notice letter sent to Saint Thomas Outpatient Neurosurgical Center, LLC along with the copies of the enclosures to the letter which include a list of the names and addresses of all healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting Saint Thomas Outpatient Neurosurgical Center, LLC to obtain complete medical records from each other provider being sent a Notice.

4. I attach as Exhibit 2 copies of the Certificates of Mailing from the United States Postal

Service, stamped with the date of mailing of the Notice and enclosures to Saint Thomas Outpatient Neurosurgical Center, LLC.

5. On July 8, 2013, I mailed by certified mail, return receipt requested a Notice letter and enclosures to Howell Allen Clinic A Professional Corporation at the address for the agent for service of process (Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste. 301, Nashville, Tn 37203-2023) and the provider's current business address (2011 Murphy Avenue, Suite 301, Nashville, TN 37203-2023) and I obtained a certificate of mailing from the United States Postal Service stamped with the date of mailing as required by Tennessee Code Annotated § 29-26-121 (a).

6. I attach as Exhibit 3 a copy of the Notice letter sent to Howell Allen Clinic A Professional Corporation along with copies of the enclosures to the letter which include a list of the names and addresses of all healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting Howell Allen Clinic A Professional Corporation to obtain complete medical records from each other provider being sent a notice.

7. I attach as Exhibit 4 a copy of the Certificate of Mailing from the United States Postal Service, stamped with the date of mailing of the Notice and enclosures to Howell Allen Clinic A Professional Corporation.

8. On July 8, 2013 I mailed by certified mail, return receipt requested a Notice letter and enclosures to Debra Schamberg, R.N., (Howell Allen Clinic, 2011 Murphy Ave., Suite 301, Nashville, TN 37203) and I obtained certificates of Mailing from the United States Postal Service stamped with the date of mailing as required by Tennessee Code Annotated § 29-26-121 (a).

9. I attach as Exhibit 5 a copy of the Notice letter sent to Debra Schamberg, R.N. along with copies of the enclosures to the letter which include a list of the names and addresses of all

healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting Debra Schamberg, R.N. to obtain complete medical records from each other provider being sent a notice.

10. I attach as Exhibit 6 copies of the Certificates of Mailing from the United States Postal Service, stamped with the date of mailing of the Notice and enclosures to Debra Schamberg, R.N.

11. On July 8, 2013, I mailed by certified mail, return receipt requested a Notice letter and enclosures to John W. Culclasure, M.D. at the address listed for Dr. Culclasure on the Tennessee Department of Health website (Howell Allen Clinic, 2011 Murphy Ave., Suite 301, Nashville, TN 37203) and at the provider's current business address (Saint Thomas Outpatient Neurosurgical Center, LLC, 2011 Murphy Ave., Ste. 301, Nashville, TN 37203-2023) and I obtained certificates of mailing from the United States Postal Service stamped with the date of mailing as required by Tennessee Code Annotated § 29-26-121 (a).

12. I attach as Exhibit 7 a copy of the Notice letter sent to John W. Culclasure, M.D., along with copies of the enclosures to the letter which include a list of the names and addresses of all healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting John W. Culclasure, M.D. to obtain complete medical records from each other provider being sent a notice.

13. I attach as Exhibit 8 copies of the Certificates of Mailing from the United States Postal Service, stamped with the date of mailing of the Notice and enclosures to John W. Culclasure, M.D.

14. On July 8, 2013, I mailed by certified mail, return receipt requested a Notice letter and enclosures to Saint Thomas Hospital at both the address for the agent for service of process (E.

Berry Holt, III, Suite 800, 102 Woodmont Blvd., Nashville, Tn 37205-2221) and the provider's current business address (4220 Harding Pike, Nashville, TN 37205-2005) and I obtained certificates of mailing from the United States Postal Service stamped with the date of mailing as required by Tennessee Code Annotated § 29-26-121 (a).

15. I attach as Exhibit 9 a copy of the Notice letter sent Saint Thomas Hospital along with copies of the enclosures to the letter which include a list of the names and addresses of all healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting Saint Thomas Hospital to obtain complete medical records from each other provider being sent a notice.

16. I attach as Exhibit 10 copies of the Certificates of Mailing from the United States Postal Service, stamped with the date of mailing of the Notice and enclosures to Saint Thomas Hospital.

17. On July 8, 2013, I mailed by certified mail, return receipt requested a Notice letter and enclosures to Saint Thomas Health Services at the address for the agent for service of process (E. Berry Holt, III, Ste. 800, 102 Woodmont Blvd., Nashville, Tn 37205-2221) and the provider's current business address (Suite 800, 102 Woodmont Blvd, Nashville, TN 37205) and I obtained a certificate of mailing from the United States Postal Service stamped with the date of mailing as required by Tennessee Code Annotated § 29-26-121 (a).

18. I attach as Exhibit 11 a copy of the Notice letter sent to Saint Thomas Health Services along with copies of the enclosures to the letter which include a list of the names and addresses of all healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting Saint Thomas Health Services to obtain complete medical records from each other provider being sent a notice.

19. I attach as Exhibit 12 a copy of the Certificate of Mailing from the United States Postal Service, stamped with the date of mailing of the Notice and enclosures to Saint Thomas Health Services.

FURTHER AFFIANT SAITH NOT.

Leigh Anne Lee

Leigh Anne Lee

STATE OF TENNESSEE

COUNTY OF WARREN

Sworn to and subscribed before me this 17 day of September, 2013.

Emily C. Hennessee

Notary Public

My Commission Expires: 9-11-17

EMILY C. HENNESSEE STATE OF TENNESSEE NOTARY PUBLIC WARREN COUNTY

Exhibit 1

LAW OFFICES OF
GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 8, 2013

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

RE: RONDA BURNS
DOB: 11/19/1962
SS#: xxx-xx-5327

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing Ronda Burns and I am the authorized agent of Ronda Burns. Through me and my firm, Ms. Burns asserted a potential claim for medical malpractice against you by notice letter dated April 16, 2013. The potential claim arises out of epidural injections of methylprednisolone acetate administered to Ronda Burns at Saint Thomas Outpatient Neurosurgical Center, LLC, on August 17 and 31, 2012.

We have now extended this notice letter to additional health care providers. We are enclosing herein an updated list of the names and addresses of all providers being sent a notice and a HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice.

You should have already forwarded the previous notice letter and enclosures to your professional liability insurance carrier and/or your legal counsel. Please let them know of this update.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

309 West Main Street McMinnville, TN 37110 931.473.8405 office 931.473.1888 fax www.galligannewmanlaw.com

OTHER PROVIDERS RECEIVING THIS NOTICE 4/16/2013
RONDA BURNS

John W. Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave. Suite 301
Nashville, TN 37203

John W. Culclasure, M.D.
Saint Thomas Outpatient Neurosurgical Center, LLC
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Timothy Schoettle, M.D.
Howell Allen Clinic
2011 Murphy Ave. Ste. 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

OTHER PROVIDERS RECEIVING THIS NOTICE 7/8/2013
RONDA BURNS

Patricia Beckham
Baptist Women's Pavilion
2011 Murphy Ave.
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, TA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: RONDA BURNS d/o/b: 11/19/1962 SS#: XXX-XX-5327

1. I authorize John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N., to Disclose my health information to John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N. The purpose(s) for the use or disclose is as follows: Litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from August 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☐ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☑ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Ronda Burns
Signature of Patient or Legal Representative

7/8/2013
Date

LAW OFFICES OF
GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 8, 2013

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2005

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RE: RONDA BURNS
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Dear Sirs:

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Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

309 West Main Street McMinnville, TN 37110 931.473.8405 office 931.473.1888 fax www.galligannewmanlaw.com

OTHER PROVIDERS RECEIVING THIS NOTICE 4/16/2013
RONDA BURNS

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Howell Allen Clinic
2011 Murphy Ave. Suite 301
Nashville, TN 37203

John W. Culclasure, M.D.
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Nashville, TN 37203-2023

Timothy Schoettle, M.D.
Howell Allen Clinic
2011 Murphy Ave. Ste. 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
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FL 9
4230 Harding Pike
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St. Thomas Hospital
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St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
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102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

OTHER PROVIDERS RECEIVING THIS NOTICE 7/8/2013
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Martin S. Kelvas, Pharmacist
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P. O. Box 380
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Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: **RONDA BURNS** do/b: 11/19/1962 SS#: XXX-XX-5327

1. I authorize John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N., to Disclose my health information to John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N. The purpose(s) for the use or disclose is as follows: Litigation.

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- ☐ Copy of Complete Records (Medical & Financial)
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- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☒ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

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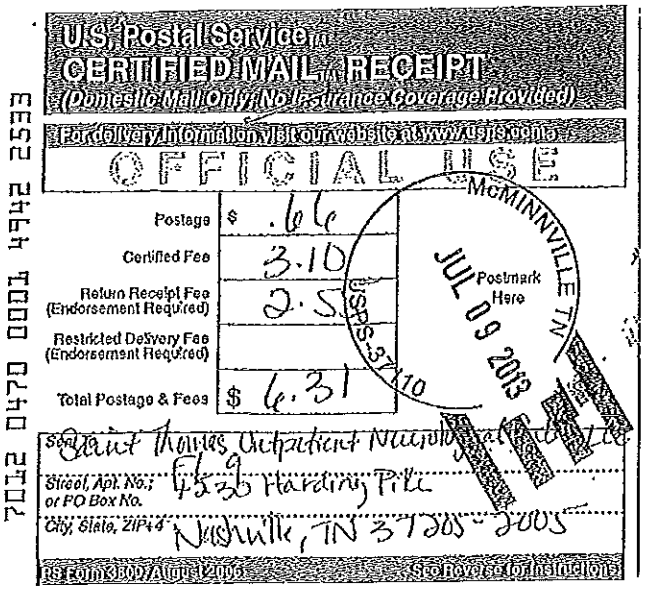
Ronda Burns
Signature of Patient or Legal Representative

7/8/2013
Date

Exhibit 2



U.S. Postal Service™
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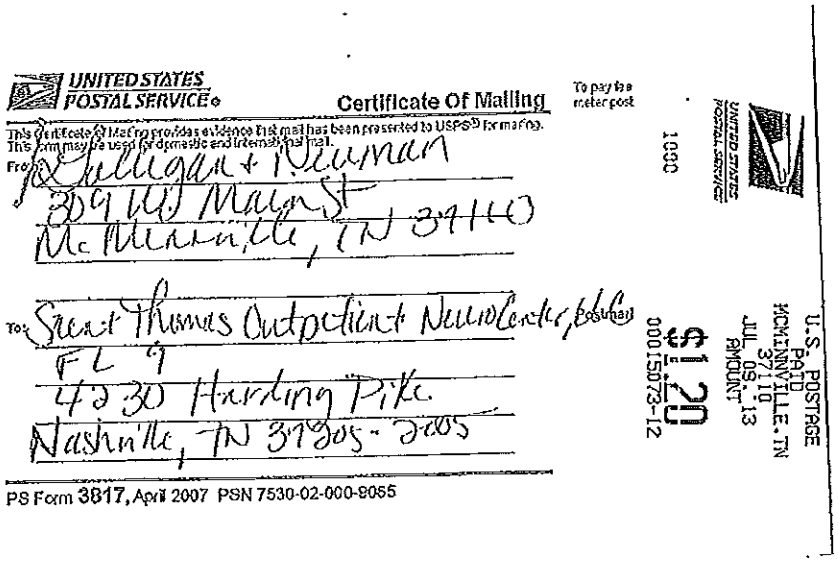
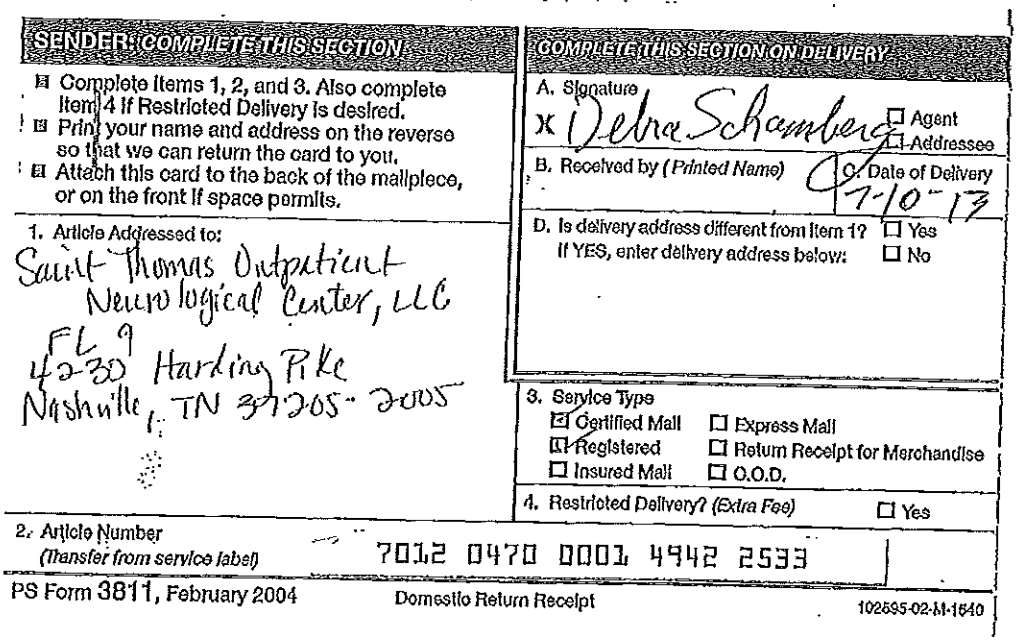
OFFICIAL USE
Postage $ .66
Certified Fee 3.10
Return Receipt Fee (Endorsement Required) 2.55
Restricted Delivery Fee (Endorsement Required)
Total Postage & Fees $ 6.31
Postmark Here
McMINNVILLE TN JUL 09 2013
USPS 37110
Sent To Saint Thomas Outpatient Neurological Center
Street, Apt. No.; or PO Box No. 4230 Harding Pike
City, State, ZIP+4 Nashville, TN 37205-2005
PS Form 3800, August 2006 See Reverse for Instructions
7012 0470 0001 4942 2533



UNITED STATES POSTAL SERVICE®
Certificate Of Mailing
To pay by meter post
This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.
From Gilligan + Newman
309 W Main St
McMinnville, TN 37110
To Saint Thomas Outpatient Neurological Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2005
PS Form 3817, April 2007 PSN 7530-02-000-9065
1000
U.S. POSTAGE PAID McMINNVILLE, TN 37110 JUL 09, 13 AMOUNT
$1.20
00015872-12



SENDER: COMPLETE THIS SECTION
- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Saint Thomas Outpatient Neurological Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2005

COMPLETE THIS SECTION ON DELIVERY
A. Signature
X Debra Schamberg ☐ Agent ☐ Addressee
B. Received by (Printed Name) C. Date of Delivery 7-10-13
D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.
4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 4942 2533
PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

7012 0470 0001 4942 2557

U.S. Postal Service™
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For delivery information visit our website at www.usps.com®
OFFICIAL USE

Postage	$ .61
Certified Fee	3.10
Return Receipt Fee (Endorsement Required)	2.55
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 6.31

McMINNVILLE TN
Postmark Here
JUL 09 2013
USPS 37110

Sent To Saint Thomas Outpatient Neuro Center, LLC
Street, Apt. No.; or PO Box No. c/o Gregory B. Lanford, MD 2011 Murphy Ave, Ste. 301
City, State, ZIP+4 Nashville, TN 37203-2023

PS Form 3800, August 2006 See Reverse for Instructions

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Gilligan & Neuman
209 W Main St
McMinnville, TN 37110

To: Saint Thomas Outpatient Neuro Center, LLC
c/o Gregory B. Lanford, MD
2011 Murphy Ave, Ste. 301
Nashville, TN 37203-2023

1000

$11.20
0001597312

U.S. POSTAGE
PAID
MCMINNVILLE, TN
37110
JUL 09, 13
AMOUNT

PS Form 3817, April 2007 PSN 7530-02-000-9065

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, MD
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X M Case ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☑ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

Article Number (Transfer from service label) 7012 0470 0001 4942 2557

Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

Exhibit 3

LAW OFFICES OF

GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 8, 2013

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

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Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

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Nashville, TN 37203

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Nashville, TN 37232

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: RONDA BURNS do/b: 11/19/1962 SS#: XXX-XX-5327

1. I authorize John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N., to Disclose my health information to John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N. The purpose(s) for the use or disclose is as follows: Litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from August 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☐ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☒ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Ronda Burns
Signature of Patient or Legal Representative

7/8/2013
Date

LAW OFFICES OF
GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Mattola John P. Partin Benjamin R. Newman M. Trevor Galligan

July 8, 2013

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

RE: RONDA BURNS
DOB: 11/19/1962
SS#: xxx-xx-5327

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing Ronda Burns and I am the authorized agent of Ronda Burns. Through me and my firm, Ms. Burns asserted a potential claim for medical malpractice against you by notice letter dated April 16, 2013. The potential claim arises out of epidural injections of methylprednisolone acetate administered to Ronda Burns at Saint Thomas Outpatient Neurosurgical Center, LLC, on August 17 and 31, 2012.

We have now extended this notice letter to additional health care providers. We are enclosing herein an updated list of the names and addresses of all providers being sent a notice and a HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice.

You should have already forwarded the previous notice letter and enclosures to your professional liability insurance carrier and/or your legal counsel. Please let them know of this update.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

OTHER PROVIDERS RECEIVING THIS NOTICE 4/16/2013
RONDA BURNS

John W. Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave. Suite 301
Nashville, TN 37203

John W. Culclasure, M.D.
Saint Thomas Outpatient Neurosurgical Center, LLC
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Timothy Schoettle, M.D.
Howell Allen Clinic
2011 Murphy Ave. Ste. 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

OTHER PROVIDERS RECEIVING THIS NOTICE 7/8/2013
RONDA BURNS

Patricia Beckham
Baptist Women's Pavilion
2011 Murphy Ave.
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, TA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

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- ☐ Summary
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- ☒ Operative/Procedure Report(OP)
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- ☐ Laboratory Report

Other: _____

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Ronda Burns
Signature of Patient or Legal Representative

7/8/2013
Date

Exhibit 4

7012 2470 0001 4942 2601

U.S. Postal Service
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

Postage	$ 1.16
Certified Fee	3.10
Return Receipt Fee (Endorsement Required)	2.55
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 6.81

McMINNVILLE TN
Postmark Here
JUL 09 2013
USPS 37110

Sent To: Howell Allen Clinic, A Professional Corp
c/o Gregory B. Lanford, MD
Street, Apt. No.; or PO Box No. 2011 Murphy Ave, Ste 301
City, State, ZIP+4 Nashville, TN 37203-2023

PS Form 3800, August 2006 See Reverse for Instructions

UNITED STATES POSTAL SERVICE

Certificate Of Mailing

To pay for mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Gilliam & Numan
207 W. Main St
McMinnville, TN 37110

To: Howell Allen Clinic A Professional
c/o Gregory B. Lanford, MD
2011 Murphy Ave, Ste 301
Nashville, TN 37110

1000

$1.20
0001507373-12

U.S. POSTAGE
PAID
MCMINNVILLE-TN
37110
JUL 09, 13
AMOUNT

PS Form 3817, April 2007 PSN 7530-02-000-9065

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Howell Allen Clinic, A Professional Corp
C/o Gregory B. Lanford, MD
2011 Murphy Ave, Ste. 301
Nashville, TN 37203-2023

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☑ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 4942 2601

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

7012 0470 0001 4442 2564

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

Postage	$ 1.16
Certified Fee	3.10
Return Receipt Fee (Endorsement Required)	2.55
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 6.31

McMINNVILLE TN Postmark Here JUL 09 2013 USPS-37110

Sent To: Howell Allen Clinic
Street, Apt. No.; or PO Box No.: 2011 Murphy Ave, Ste. 301
City, State, ZIP+4: Nashville, TN 37203-2023

PS Form 3800, August 2006 — See Reverse for Instructions

UNITED STATES POSTAL SERVICE® — **Certificate Of Mailing**

To pay fee, affix meter postage

1000

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form is not for domestic end international mail.

From: Kelligan J. Kellogan
209 E. Main Street
McMinnville, TN 37110

To: Howell Allen Clinic, A Professional Corp.
2011 Murphy Ave Ste 301
Nashville, TN 37203-2023

Postmark

$6.15
0301523-12

PAID
MCMINNVILLE, TN
37110
JUL 09, 13
AMOUNT

PS Form 3817, April 2007 PSN 7530-02-000-9065

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Howell Allen Clinic
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☑ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 4442 2564

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

Exhibit 5

LAW OFFICES OF

GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Martula John P. Partin Benjamin R. Newman M. Trevor Galligan

July 8, 2013

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

RE: RONDA BURNS
DOB: 11/19/1962
SS#: xxx-xx-5327

Dear Nurse Schamberg:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing Ronda Burns and I am the authorized agent of Ronda Burns. Through me and my firm, Ms. Burns is asserting a potential claim for medical malpractice against you. This claim arises out of epidural injections of methylprednisolone acetate administered to Ronda Burns at Saint Thomas Outpatient Neurosurgical Center, LLC, on August 17 and 31, 2012.

Enclosed herein is a list of the names and addresses of all providers being sent a notice. Also enclosed are HIPAA compliant medical authorizations permitting you to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence and enclosures to your professional liability insurance carrier and/or your legal counsel. Please ask your representative (either a representative from your professional liability insurance carrier or your legal counsel) to contact me.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

309 West Main Street McMinnville, TN 37110 931.473.8405 office 931.473.1888 fax www.galligannewmanlaw.com

OTHER PROVIDERS RECEIVING THIS NOTICE 4/16/2013
RONDA BURNS

John W. Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave. Suite 301
Nashville, TN 37203

John W. Culclasure, M.D.
Saint Thomas Outpatient Neurosurgical Center, LLC
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Timothy Schoettle, M.D.
Howell Allen Clinic
2011 Murphy Ave. Ste. 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

OTHER PROVIDERS RECEIVING THIS NOTICE 7/8/2013
RONDA BURNS

Patricia Beckham
Baptist Women's Pavilion
2011 Murphy Ave.
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, TA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: RONDA BURNS d/o/b: 11/19/1962 SS#: XXX-XX-5327

1. I authorize John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N., to Disclose my health information to John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N. The purpose(s) for the use or disclose is as follows: Litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from August 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☐ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☒ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

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Ronda Burns
Signature of Patient or Legal Representative

7/8/2013
Date

Exhibit 6

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
OFFICIAL USE

Postage	$ .61
Certified Fee	3.10
Return Receipt Fee (Endorsement Required)	2.55
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 6.31

McMINNVILLE TN Postmark Here JUL 09 2013

Sent To: Debra Schamberger, RN
Street, Apt. No.; or PO Box No.: Howell Allen Clinic, 37110 2011 Murphy Ave, Ste 301
City, State, ZIP+4: Nashville, TN 37203

7012 0470 0001 4942 2540

PS Form 3800, August 2006 — See Reverse for Instructions

UNITED STATES POSTAL SERVICE®
Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Elizabeth McNuman
389 W. Main St
McMinnville, TN 37110

To: Debra Schamberg, RN
Howell Allen Clinic
2011 Murphy Ave, Ste. 301
Nashville, TN 37203

1000

UNITED STATES POSTAL SERVICE

U.S. POSTAGE PAID MCMINNVILLE, TN 37110 JUL 08, '13 AMOUNT $1.20 00015073-12

PS Form 3817, April 2007 PSN 7530-02-000-9065

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Debra Shamberg, RN
Howell Allen Clinic
2011 Murphy Ave, Ste. 301
Nashville, TN 37203

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

Article Number (Transfer from service label) 7012 0470 0001 4942 2540

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

Exhibit 1.

LAW OFFICES OF

GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 8, 2013

John W. Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave. Suite 301
Nashville, TN 37203
CERTIFIED MAIL - RETURN RECEIPT REQUESTED

RE: RONDA BURNS
DOB: 11/19/1962
SS#: xxx-xx-5327

Dear Dr. Culclasure:

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GALLIGAN & NEWMAN

Michael D. Galligan

309 West Main Street McMinnville, TN 37110 931.473.8405 office 931.473.1888 fax www.galliganewmanlaw.com

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Nashville, TN 37203-2023

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Nashville, TN 37203

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Nashville, TN 37203-2023

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

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Nashville, TN 37203-2023

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4230 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
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Debra Schamberg, R.N.
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- ☐ Laboratory Report

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Ronda Burns
Signature of Patient or Legal Representative

7/8/2013
Date

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GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marcala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 8, 2013

John W. Culclasure, M.D.
Saint Thomas Outpatient Neurosurgical Center, LLC
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

RE: RONDA BURNS
DOB: 11/19/1962
SS#: xxx-xx-5327

Dear Dr. Culclasure:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing Ronda Burns and I am the authorized agent of Ronda Burns. Through me and my firm, Ms. Burns asserted a potential claim for medical malpractice against you by notice letter dated April 16, 2013. The potential claim arises out of epidural injections of methylprednisolone acetate administered to Ronda Burns at Saint Thomas Outpatient Neurosurgical Center, LLC, on August 17 and 31, 2012.

We have now extended this notice letter to additional health care providers. We are enclosing herein an updated list of the names and addresses of all providers being sent a notice and a HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice.

You should have already forwarded the previous notice letter and enclosures to your professional liability insurance carrier and/or your legal counsel. Please let them know of this update.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

OTHER PROVIDERS RECEIVING THIS NOTICE 4/16/2013
RONDA BURNS

John W. Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave. Suite 301
Nashville, TN 37203

John W. Culclasure, M.D.
Saint Thomas Outpatient Neurosurgical Center, LLC
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Timothy Schoettle, M.D.
Howell Allen Clinic
2011 Murphy Ave. Ste. 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

OTHER PROVIDERS RECEIVING THIS NOTICE 7/8/2013
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Patricia Beckham
Baptist Women's Pavilion
2011 Murphy Ave.
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, TA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: RONDA BURNS dob: 11/19/1962 SS#: XXX-XX-5327

1. I authorize John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N., to Disclose my health information to John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N. The purpose(s) for the use or disclose is as follows: Litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from August 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☐ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☒ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Ronda Burns
Signature of Patient or Legal Representative

7/8/2013
Date

Exhibit 8

7012 0470 0001 4942 2625

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
OFFICIAL USE

Postage	$ .46
Certified Fee	3.10
Return Receipt Fee (Endorsement Required)	2.55
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 6.31

McMINNVILLE TN
Postmark Here
JUL 09 2013
USPS-37119

Sent To: John W. Culclasure, MD
Howell Allen Clinic
Street, Apt. No.; or PO Box No.: 2011 Murphy Ave, Ste 301
City, State, ZIP+4: Nashville, TN 37203

PS Form 3800, April 2006 See Reverse for Instructions

UNITED STATES POSTAL SERVICE®

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This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may not be used for domestic and international mail.

From: Gilliland & Neuman
309 W Main St
McMinnville, TN 37110

To: John W. Culclasure, MD
Howell Allen Clinic
2011 Murphy Ave, Ste 301
Nashville, TN 37203

1000

U.S. POSTAGE PAID MCMINNVILLE, TN 37110 JUL 09, '13 AMOUNT $1.20 00015073-12

PS Form 3817, April 2007 PSN 7530-02-000-9065

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
John W. Culclasure, MD
Howell Allen Clinic
2011 Murphy Ave, Ste 301
Nashville, TN 37203

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label): 7012 0470 0001 4942 2625

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

7012 0470 0001 4942 2632

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
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For delivery information visit our website at www.usps.com®

OFFICIAL USE

Postage	$ 1.66
Certified Fee	3.10
Return Receipt Fee (Endorsement Required)	2.55
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 12.31

Postmark Here: MCMINNVILLE TN JUL 09 2013 USPS

Sent To: John W. Culclasure, MD Saint Thomas Outpatient Neurological Center, LLC
Street, Apt. No.; or PO Box No.: 2011 Murphy Ave, Ste 301
City, State, ZIP+4: Nashville, TN 37203-2023

PS Form 3800, August 2006 — See Reverse for Instructions

UNITED STATES POSTAL SERVICE® — **Certificate Of Mailing**

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may not be used for international mail.

From: Gilligan + Neuman
309 W Main St
McMinnville, TN 37110

To: John W Culclasure MD
Saint Thomas Outpatient Neuro Center, LLC
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

To pay fee, meter post: 1000

Postmark: $11.21 0001507-12

U.S. POSTAGE PAID MCMINNVILLE-TN 37110 JUL 08, 13 AMOUNT

PS Form 3817, April 2007 PSN 7530-02-000-9065

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
John W. Culclasure, MD
Saint Thomas Outpatient Neurological Center, LLC
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

COMPLETE THIS SECTION ON DELIVERY

A. Signature: x M. Gee ☐ Agent ☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 4942 2632

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

Exhibit 9

LAW OFFICES OF
GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 8, 2013

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

RE: RONDA BURNS
DOB: 11/19/1962
SS#: xxx-xx-5327

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing Ronda Burns and I am the authorized agent of Ronda Burns. Through me and my firm, Ms. Burns asserted a potential claim for medical malpractice against you by notice letter dated April 16, 2013. The potential claim arises out of epidural injections of methylprednisolone acetate administered to Ronda Burns at Saint Thomas Outpatient Neurosurgical Center, LLC, on August 17 and 31, 2012.

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Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

309 West Main Street McMinnville, TN 37110 931.473.8405 office 931.473.1888 fax www.galligannewmanlaw.com

OTHER PROVIDERS RECEIVING THIS NOTICE 4/16/2013
RONDA BURNS

John W. Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave. Suite 301
Nashville, TN 37203

John W. Culclasure, M.D.
Saint Thomas Outpatient Neurosurgical Center, LLC
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Timothy Schoettle, M.D.
Howell Allen Clinic
2011 Murphy Ave. Ste. 301
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Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
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St. Thomas Hospital
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Suite 800
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Nashville, TN 37205-2221

Saint Thomas Health Services
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102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
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102 Woodmont Blvd.
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2011 Murphy Ave.
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Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: RONDA BURNS do/b: 11/19/1962 SS#: XXX-XX-5327

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Ronda Burns
Signature of Patient or Legal Representative

7/8/2013
Date

LAW OFFICES OF
GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 8, 2013

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

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Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: RONDA BURNS do/b: 11/19/1962 SS#: XXX-XX-5327

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Other: _____

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Ronda Burns
Signature of Patient or Legal Representative

7/8/2013
Date

Exhibit 10

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Certified Fee	3.10
Return Receipt Fee (Endorsement Required)	2.55
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 6.31

McMINNVILLE TN
Postmark Here
JUL 09 2013
USPS-37110

Sent To: Saint Thomas Health Services c/o E. Berry Holt, III
Street, Apt. No.; or PO Box No.: Suite 800 102 Woodmont Blvd
City, State, ZIP+4: Nashville, TN 37205-2221

PS Form 3800, August 2006 — See Reverse for Instructions

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309 W Main St
McMinnville, TN 37110

To: Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville TN 37205-2221

1000

U.S. POSTAGE PAID MCMINNVILLE-TN 37110 JUL 09'13 AMOUNT $1.20 00015073-12

PS Form 3817, April 2007 PSN 7530-02-000-9065

SENDER: COMPLETE THIS SECTION

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addressee

B. Received by (Printed Name): [signature] C. Date of Delivery: 7/10/13

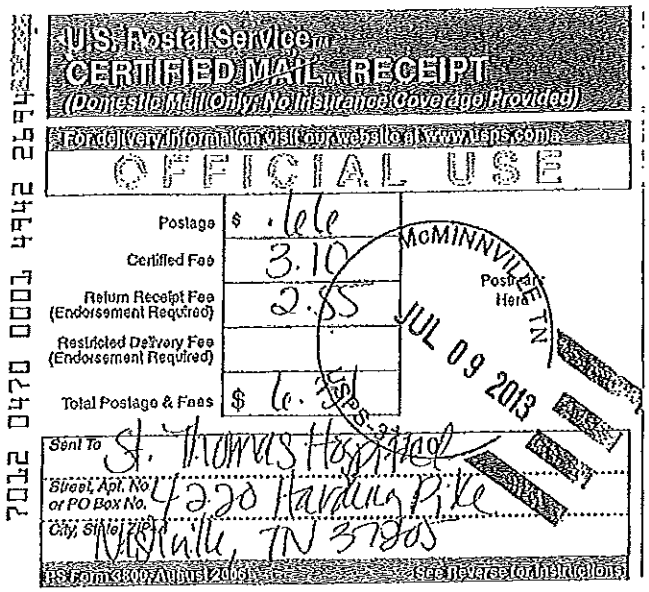
D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☑ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label): 7012 0470 0001 4942 2687

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540



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For delivery information visit our website at www.usps.com®
OFFICIAL USE

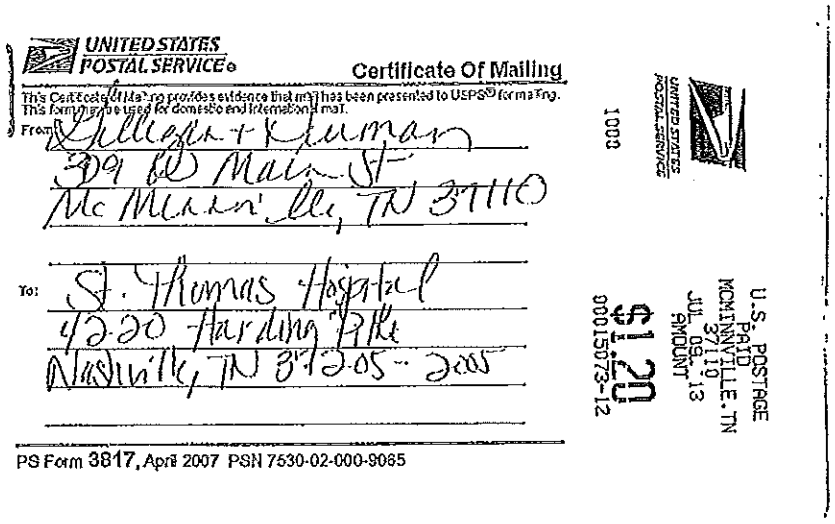
Postage	$ .46
Certified Fee	3.10
Return Receipt Fee (Endorsement Required)	2.55
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 6.30

McMINNVILLE, TN JUL 09 2013

Sent To: St. Thomas Hospital
Street, Apt. No. or PO Box No.: 4220 Harding Pike
City, State, ZIP+4: Nashville, TN 37205

PS Form 3800, August 2006 See Reverse for Instructions

7012 0470 0001 4942 2694



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Certificate Of Mailing

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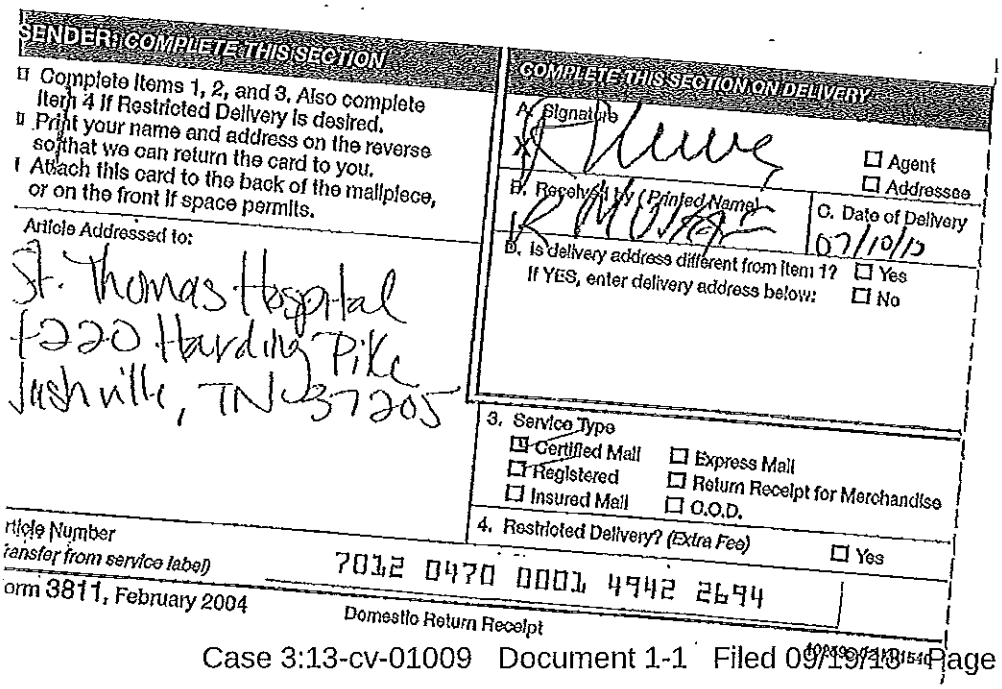
From: Gilleran + Kinman
309 W Main St
McMinnville, TN 37110

To: St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

1003

U.S. POSTAGE PAID MCMINNVILLE, TN 37110 JUL 09 13 AMOUNT $1.20 00015072-12

PS Form 3817, April 2007 PSN 7530-02-000-9065



SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

Article Addressed to:
St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205

COMPLETE THIS SECTION ON DELIVERY

A. Signature: X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name): K Miller C. Date of Delivery: 07/10/13

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

Article Number (Transfer from service label): 7012 0470 0001 4942 2694

PS Form 3811, February 2004 Domestic Return Receipt

Exhibit 11

LAW OFFICES OF
GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 8, 2013

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

RE: RONDA BURNS
DOB: 11/19/1962
SS#: xxx-xx-5327

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing Ronda Burns and I am the authorized agent of Ronda Burns. Through me and my firm, Ms. Burns asserted a potential claim for medical malpractice against you by notice letter dated April 16, 2013. The potential claim arises out of epidural injections of methylprednisolone acetate administered to Ronda Burns at Saint Thomas Outpatient Neurosurgical Center, LLC, on August 17 and 31, 2012.

We have now extended this notice letter to additional health care providers. We are enclosing herein an updated list of the names and addresses of all providers being sent a notice and a HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice.

You should have already forwarded the previous notice letter and enclosures to your professional liability insurance carrier and/or your legal counsel. Please let them know of this update.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

309 West Main Street McMinnville, TN 37110 931.473.8405 office 931.473.1888 fax www.galligannewmanlaw.com

OTHER PROVIDERS RECEIVING THIS NOTICE 4/16/2013
RONDA BURNS

John W. Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave. Suite 301
Nashville, TN 37203

John W. Culclasure, M.D.
Saint Thomas Outpatient Neurosurgical Center, LLC
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Timothy Schoettle, M.D.
Howell Allen Clinic
2011 Murphy Ave. Ste. 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

OTHER PROVIDERS RECEIVING THIS NOTICE 7/8/2013
RONDA BURNS

Patricia Beckham
Baptist Women's Pavilion
2011 Murphy Ave.
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, TA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: RONDA BURNS d/o/b: 11/19/1962 SS#: XXX-XX-5327

1. I authorize John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N., to Disclose my health information to John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N. The purpose(s) for the use or disclose is as follows: Litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from August 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☐ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☒ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Ronda Burns
Signature of Patient or Legal Representative

7/8/2013
Date

LAW OFFICES OF
GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Martula John P. Partin Benjamin R. Newman M. Trevor Galligan

July 8, 2013

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

RE: RONDA BURNS
DOB: 11/19/1962
SS#: xxx-xx-5327

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing Ronda Burns and I am the authorized agent of Ronda Burns. Through me and my firm, Ms. Burns asserted a potential claim for medical malpractice against you by notice letter dated April 16, 2013. The potential claim arises out of epidural injections of methylprednisolone acetate administered to Ronda Burns at Saint Thomas Outpatient Neurosurgical Center, LLC, on August 17 and 31, 2012.

We have now extended this notice letter to additional health care providers. We are enclosing herein an updated list of the names and addresses of all providers being sent a notice and a HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider being sent a notice.

You should have already forwarded the previous notice letter and enclosures to your professional liability insurance carrier and/or your legal counsel. Please let them know of this update.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

309 West Main Street McMinnville, TN 37110 931.473.8405 office 931.473.1888 fax www.galliganewmanlaw.com

OTHER PROVIDERS RECEIVING THIS NOTICE 4/16/2013
RONDA BURNS

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Howell Allen Clinic
2011 Murphy Ave. Suite 301
Nashville, TN 37203

John W. Culclasure, M.D.
Saint Thomas Outpatient Neurosurgical Center, LLC
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Timothy Schoettle, M.D.
Howell Allen Clinic
2011 Murphy Ave. Ste. 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave. Ste. 301
Nashville, TN 37203-2023

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

OTHER PROVIDERS RECEIVING THIS NOTICE 7/8/2013
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Patricia Beckham
Baptist Women's Pavilion
2011 Murphy Ave.
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, TA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: RONDA BURNS dob: 11/19/1962 SS#: XXX-XX-5327

1. I authorize John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N., to Disclose my health information to John Culclasure, M.D., Timothy Schoettle, M.D., Howell Allen Clinic, Saing Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, Saint Thomas Health Services, Patricia Beckham, Martin S. Kelvas, pharmacist, Michael O'Neal, Debra Schamberg, R.N. The purpose(s) for the use or disclose is as follows: Litigation.

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Health information covering treatment from August 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
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- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☒ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

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Ronda Burns
Signature of Patient or Legal Representative

7/8/2013
Date

Exhibit 12

7012 0470 0001 4942 2588

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

OFFICIAL USE

Postage	$ .46
Certified Fee	3.10
Return Receipt Fee (Endorsement Required)	2.55
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 6.31

McMINNVILLE TN JUL 09 2013 USPS 37110

Sent To: St. Thomas Hospital c/o E. Berry Holt, III
Street, Apt. No.; or PO Box No.: Suite 800 102 Woodmont Blvd
City, State, ZIP+4: Nashville, TN 37205-2221

PS Form 3800, August 2006 — See Reverse for Instructions

UNITED STATES POSTAL SERVICE® — **Certificate Of Mailing**

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may not be used for domestic and international mail.

From: Gilliam & Kumon
309 W. Main St
McMinnville, TN 37110

To: St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd
Nashville, TN 37205-2221

1000

U.S. POSTAGE PAID MCMINNVILLE, TN 37110 JUL 09 '13 AMOUNT $1.20 00015073-12

PS Form 3817, April 2007 PSN 7530-02-000-9065

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery 7/10/13

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☑ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0001 4942 2588

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

7012 0470 0001 4942 2654

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

Postage	$ 1.16
Certified Fee	3.10
Return Receipt Fee (Endorsement Required)	2.55
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 6.81

McMINNVILLE TN
Postmark Here
JUL 09 2013
USPS 37110

Sent To: Saint Thomas Health Services Suite 820
Street, Apt. No., or PO Box No.: 102 Woodmont Blvd
City, State, ZIP+4: Nashville, TN 37205

PS Form 3800, August 2006 — See Reverse for Instructions

UNITED STATES POSTAL SERVICE® — **Certificate Of Mailing**

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may not be used for domestic and international mail.

From: Gilligan & Neuman
39 W Main St
McMinnville, TN 37110

To: Saint Thomas Health Services
Suite 820
102 Woodmont Blvd
Nashville, TN 37205

1000

UNITED STATES POSTAL SERVICE

U.S. POSTAGE PAID MCMINNVILLE, TN 37110 JUL 09 '13 AMOUNT

$1.20
00015073-12

PS Form 3817, April 2007 PSN 7530-02-000-9065

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Saint Thomas Health Services
Suite 820
102 Woodmont Blvd.
Nashville, TN 37205

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addressee

B. Received by (Printed Name): Mesdenberg — C. Date of Delivery: 7/10/13

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☑ No

3. Service Type
☐ Certified Mail ☐ Express Mail
☑ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7012 0470 0001 4942 2654

PS Form 3811, February 2004 — Domestic Return Receipt — 102595-02-M-1540